whether the patient belonged to a health maintenance organization (HMO), whether authorization was required for the visit, and whether the visit was capitated.

A key concept of managed care is the ability of the primary care physician to manage the patient's care, to use tests, and to refer patients to specialists. Overall, one-third (35.4 percent) of all OPD visits were to the patient's primary care physician (table 4).

An HMO is defined as a health care delivery system that offers comprehensive health services provided by an established panel or network of providers to a voluntarily enrolled population for a prepaid fixed fee and whose members are required to utilize services within the panel of contracted providers. This item permits estimation of the volume of visits by patients who are members of an HMO and should, by definition, be receiving managed care. As shown in table 4, 21.9 percent of all visits were made by patients who belong to an HMO. Visits by HMO patients and by patients who were not members of HMO's were equally likely to be to the patient's primary care physician (37.9 percent versus 36.1 percent.)

Authorization was required to see the physician at 12.6 percent of OPD visits (table 4). However, visits to physicians other than the patient's primary care physician were more likely to require authorization (17.6 percent versus 7.0 percent for visits to the patient's primary care physician). Capitated visits accounted for 10.9 percent of all OPD visits in 1998. Visits where patients saw their primary care physician were more likely to be capitated compared with visits where patients saw a physician other than their primary care physician (16.8 percent versus 8.4 percent). It should be noted that there are fairly high levels of missing data for the capitation item (34.6 percent), so the results should be interpreted with caution.

Primary expected source of payment—Data for this item are shown in table 5 and figure 4. Private insurance was cited most frequently (33.8 percent of visits). The distribution of expected payment sources in 1998 did not differ significantly from the corresponding 1997 figures.

The expected source of payment distribution of OPD visits for HMO members was different from the distribution of visits by patients who were not members of an HMO. The majority of visits by HMO members had private insurance checked (61.4 percent), 25.2 percent had Medicaid, and 4.2 percent had Medicare. In contrast, the most frequently reported category for visits by non-HMO members was Medicaid (28.3 percent), followed by private insurance (25.4 percent), and Medicare (20.1 percent). The percent of self-pay visits was 13.8 percent for non-HMO members compared with less than 1 percent for HMO members (data not shown). It should be kept in mind that HMO status was not known for 23.2 percent of visits. More complete reporting could change the distributions.

Examining those visits with private insurance as the expected source of payment and with a known HMO status, 49.1 percent were by patients who were HMO members. Among Medicaid and Medicare visits, 26.2 percent and 7.7 percent, respectively, were by HMO members (data not shown).

Patient's principal reason for visit—As described earlier, up to three reasons for visit were coded and classified according to *A Reason for Visit Classification for Ambulatory Care* (RVC) (5). The principal reason for visit is the problem, complaint, or reason provided in the patient's own words. The RVC is divided into eight modules or groups of reasons, which are displayed in table 6. Reasons classified in the symptom module represented 42.2 percent of all OPD visits with symptoms referable to the respiratory system accounting for 8.5 percent. The diagnostic/screening and preventive module (18.2 percent) and the treatment module (18.4 percent) were also prominent.

The 20 most frequently mentioned principal reasons for visit, representing 43.7 percent of all visits, are shown in table 7. Progress visit, classified in the treatment module and generally denoting routine followup of an unspecified problem, was the most frequently mentioned principal reason for visit (9.1 percent). This was followed by general medical examination (6.1 percent) and routine prenatal examination (3.3 percent). The most frequently mentioned reasons related to a symptomatic problem were cough (2.8 percent), throat symptoms (2.0 percent), stomach and abdominal pain (1.6 percent), and fever (1.6 percent). Seventeen of the top 20 reasons for OPD visits in 1998 were also listed among the most frequently mentioned reasons in 1997, albeit in a different order. It should be noted that estimates differing in ranked order may not be significantly different from each other.

Major reason for this visit—The intent of this new item on the 1997–98 NHAMCS Patient Record form was to provide a better picture of the general nature of the OPD visit—whether for an acute problem; routine chronic problem; flareup of a chronic problem; pre- or

Table 5. Number and percent distribution of outpatient department visits with corresponding standard errors by primary expected source of payment: United States, 1998

Primary expected source of payment	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	75,412	7,609	100.0	. . .
Private insurance	25,469	3,680	33.8	2.7
Medicaid	19,543	2,208	25.9	2.4
Medicare	12,237	1,710	16.2	1.3
Self-pay	7,030	1,008	9.3	0.9
No charge	*2,363	942	*3.1	1.2
Worker's compensation	567	99	0.8	0.1
Other	4,489	824	6.0	1.0
Unknown/blank	3,715	635	4.9	0.7

. . . Category not applicable.
*Figure does not meet standard of reliability or precision.
NOTE: Numbers may not add to totals because of rounding.